Chapter One

# Overview of the Managed Competition Act

The Managed Competition Act of 1993 seeks to slow the growth of health costs and expand health insurance coverage by adopting the managed competition approach to health care financing.[1] This approach, which was developed by a group of experts in health policy known as the Jackson Hole Group, emphasizes motivating consumers, insurers, and providers to be more cost-conscious, and it tries to imbue the health care system with the efficiency, flexibility, and innovation of competitive markets, without the undesirable outcomes of the present system. It leaves much decisionmaking decentralized. Managed competition also pursues expanded access to health insurance coverage, partly because that is an objective in its own right and partly because shrinking the pool of uninsured people would enhance the effectiveness of other changes designed to contain costs.[2]

The Managed Competition Act would regulate the health insurance market to make insurance more available and affordable, but it would not require either employers or individuals to purchase insurance. Various incentives would encourage health care providers, insurers, and consumers to focus more on the cost and quality of care; the government, though, would not limit insurance premiums, reimbursement rates, or total spending for health.

The proposal would create a system of managed competition consisting of a federal Health Care Standards Commission, regional health plan purchasing cooperatives (HPPCs), and a large number of accountable health plans (AHPs). It would repeal Medicaid and establish a new federal program that would help low-income people purchase health insurance coverage from an accountable health plan. Other provisions are designed to improve access to health care in rural and other underserved areas, expand preventive health programs, establish uniform standards for malpractice claims, and simplify the administration of health insurance. For the most part, the system of managed competition created by the proposal would not affect the Medicare program or private medigap health insurance policies.

## Managed Competition

Managed competition is intended to encourage health insurers and health care providers to compete by offering high-quality, low-cost care and not by risk selecting--that is, by attempting to cover only the healthiest individuals. Under the proposal, a Health Care Standards Commission would oversee the health insurance market and establish a standard benefit package and other criteria for accountable health plans. Changes in the tax code would strongly encourage the use of accountable health plans. Regional health plan purchasing cooperatives would allow individuals and small groups to pur-

1. H.R. 3222 was introduced by Congressman Jim Cooper and has 57 current cosponsors. A similar Senate bill, S. 1579, was introduced by Senator John Breaux and has three cosponsors. For an analysis of an earlier version of the bill, see "Estimates of Health Care Proposals from the 102nd Congress," CBO Paper (July 1993), Chapter 5.

2. See Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (May 1993).

chase health insurance on much the same terms as large groups. Firms would be required to offer health insurance to their employees but would not be required to pay for it. People eligible for Medicare would continue to receive health benefits through that program and would not participate in accountable health plans.

## Health Care Standards Commission

A new federal Health Care Standards Commission would be created to oversee the system of managed competition. The commission would specify a uniform set of health insurance benefits, and the commission's recommendations would go into effect unless overturned by a joint resolution of the Congress. These recommendations would supersede state laws requiring insurers to cover specific health care services. The commission would establish uniform cost-sharing requirements for all health plans, but no cost sharing would be allowed for clinical preventive health services. The commission would set these cost-sharing requirements to ensure that the use of health care services by the currently insured would not increase. It would also establish standards for reporting prices, health outcomes, and measures of consumer satisfaction. Plans that met the commission's standards would be registered as accountable health plans.

The commission would also play a substantial role in the ongoing operation of the health care system. It would determine the eligibility of low-income families for subsidies, distribute subsidies to health plans on behalf of eligible families, ensure that any shortfalls in subsidies for premiums were shared equitably among AHPs, set up a methodology for allocating risks among health plans within each HPPC, coordinate the payment of premiums to health plans when employees resided outside their employer's HPPC area, provide for the auditing of health plans, monitor the reinsurance market for health plans, ensure that enrollees were protected against the potential insolvency of their health plan, establish standards for a national health data system, and conduct various analyses of health care expenditures and use. By 1997, the commission would also submit to the Congress recommendations for achieving universal health insurance coverage, including one regarding an individual mandate to purchase health insurance.

## Accountable Health Plans

Accountable health plans would provide health coverage in a variety of ways. Some, such as health maintenance organizations, might offer health insurance and health care as a single product. Others might provide indemnity insurance benefits. AHPs would be of two types--closed and open. Closed plans generally would be limited to employees of firms employing more than 100 people, participants in plans established under a collective bargaining agreement prior to September 1993, and students enrolled in a university or college. Closed plans would be required to offer health insurance to all members of the relevant group and would not be offered through a health plan purchasing cooperative. Open plans would be required to accept all eligible applicants and would be available only through a HPPC.

AHPs would be prohibited from basing premiums on a person's health status or previous claims but could differentiate among demographic groups. The Health Care Standards Commission would establish premium classes based on type of enrollment and age. The proposal provides for four types of enrollment--individual, individual and spouse, individual and one child, and individual and family; the age groups would be established by the commission. In general, each open AHP would establish a standard premium for its plan in each HPPC in which it was offered. The premium charged for each class would equal the standard premium multiplied by a premium class factor, which the commission would determine. Closed AHPs would also establish a standard premium, but they could base premiums only on type of enrollment and could disregard the adjustment for age. Closed AHPs would also be allowed, but not required, to establish common premiums for two or more HPPC areas.

An accountable health plan could offer more benefits than the standard package, but these items would have to be offered and priced separately from the uniform benefit package. No AHP or other insurer could offer benefits that duplicated those in

the standard package or reduce cost sharing below the uniform amounts established by the commission.

Accountable health plans would face extensive requirements for reporting information, which would have to be collected and transmitted to the Health Care Standards Commission or the local HPPC in standardized formats. Plans would have to provide information on their preventive health activities, outcomes of treatments, and consumer satisfaction. Moreover, plans would be taxed for failing to comply with these requirements and would be prohibited from paying providers who failed to report the required information. AHPs would also have to pay several taxes and assessments, including taxes on premiums to finance graduate medical education and assessments to equalize the burden of any shortfalls in subsidies for premiums for low-income families.

All open AHPs that are health maintenance organizations (HMOs) would have to become Medicare risk contractors--that is, if Medicare beneficiaries chose to enroll, the plans would have to provide services for a predetermined periodic payment from Medicare and would not be reimbursed separately for each service provided. All other AHPs (including closed plans) would be required to make compensating payments if the Health Care Standards Commission found that Medicare risk contracting put open HMO plans at a disadvantage.

Changes in the tax code would strongly encourage the use of accountable health plans. The proposal would limit the tax deductibility of health insurance spending to the "reference premium rate," which is the lowest premium for the individual's premium class charged by an open AHP enrolling a significant percentage of eligible individuals in the local HPPC. A 35 percent excise tax would be imposed on employers' payments for health insurance or a self-insured plan above the reference premium, as well as on all payments to plans that were not AHPs.[3] Individuals (both employed and self-employed) could take an income tax deduction for premiums paid to an accountable health plan, but the individual and the employer could together deduct no more than the reference premium. Unlike the present deduction for medical expenses, the proposed deduction for premiums would be available to all individual taxpayers, even if they did not itemize their deductions or their medical expenses did not exceed 7.5 percent of adjusted gross income.

## Health Plan Purchasing Cooperatives

Each state would set up health plan purchasing cooperatives through which individuals and small businesses would have access to health insurance coverage. Except for those individuals working for businesses with more than 100 employees, everyone would generally be required to purchase their accountable health plan through the HPPC to receive a tax deduction. States would have the flexibility to make larger firms participate in the HPPC, as long as no more than half of the employees in the state would be eligible to purchase insurance through HPPCs. Each HPPC would cover an exclusive geographic area--an entire state, a portion of a state, or an interstate region. Once a year, a HPPC would offer each eligible individual the option of enrolling in any one of the open AHPs available in its area. This open enrollment period would have to last at least 30 days. During this period, the HPPC would provide standardized information on each open plan, including data on price, quality of care, and consumer satisfaction. The HPPC could also collect and disseminate information on the quality of care provided by closed AHPs in its area; if the HPPC did not do so, the Health Care Standards Commission would perform this task.

The HPPC would collect all premiums from individual purchasers and small businesses and distribute them to the open AHPs. Small businesses would have to enter into an agreement with the local HPPC, furnish the appropriate HPPC with the name and address of each employee, and provide for the payroll deduction of an individual's premium; employers would not be required to enroll their employees in a plan or contribute to the cost of coverage. Using a procedure to be established by the Health Care Standards Commission, the HPPC would pay relatively more to open AHPs that en-

3. H.R. 3222 and S. 1579 would set the excise tax rate at 34 percent, the top tax rate on corporate income in effect when the bills were drafted. The sponsors have told CBO that they intend the excise tax rate to equal the current top corporate tax rate, which was raised to 35 percent in the Omnibus Budget Reconciliation Act of 1993.

rolled high-risk individuals and less to AHPs with low-risk enrollees. The proposal provides for no adjustment of risks among HPPCs or between open and closed AHPs. The expenses of the HPPC would be financed by a surcharge on premiums for insurance bought through the HPPC. HPPCs would be prohibited from any actions that affected premiums, the reimbursement of providers, or the performance of AHPs.

Like small firms, large firms (in general, those with more than 100 employees) would be required to provide an accountable health plan in which their employees could enroll and to provide for the payroll deduction of premiums. Unlike small businesses, large firms could not offer a plan through the local HPPC, but rather would have to contract directly with a plan offered outside the HPPC or establish a self-insured plan. Insurers offering AHPs in the non-HPPC marketplace would not be required to charge large firms the same rate charged enrollees in the HPPC or the same rate charged employees of other large firms. Thus, the cost of the least expensive AHP available to a large firm might exceed the reference premium. In such situations, employers would be required to contribute to their employees' coverage. They would have to pay the difference between the lowest available premium and the reference premium to ensure that their employees could obtain coverage at no more than the reference rate.

Because people would always have access to health insurance coverage, either through the local HPPC or their employer, the proposal would repeal the so-called COBRA requirement for continuation coverage. Currently, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers providing health insurance and with 20 or more employees must allow participants and other beneficiaries to purchase continuing coverage for at least 18 months after coverage would otherwise cease--for example, because of job loss, death, or divorce.

# Assistance to Low-Income People

The Managed Competition Act would repeal Medicaid and establish a new program to assist many more low-income people with the costs of health care. The federal government would provide subsidies for health insurance premiums, cost-sharing requirements, and certain benefits commonly covered under Medicaid that were not part of the standard benefit package. Medicare beneficiaries would be eligible for similar subsidies. The Health Care Standards Commission would be responsible for taking applications for low-income assistance, verifying the information provided, computing the amount of assistance, and distributing subsidies to health plans on behalf of eligible families. The subsidies and other budgetary costs would be financed by repealing Medicaid, limiting the deductibility of health insurance expenses for employers, reducing certain payments under Medicare, and making other changes in taxes and spending.

## Subsidies for Premiums and Cost Sharing

For people not eligible for Medicare, the subsidy of their premium would be based on the reference premium--the premium for the least expensive AHP enrolling a significant number of people in the HPPC. In general, those with adjusted gross income up to 100 percent of the poverty level (adjusted for the state's cost of living) would be eligible for a federal subsidy equal to the reference premium. The subsidy would be phased out for people with incomes between 100 percent and 200 percent of the state-adjusted poverty level. Recipients of Aid to Families with Dependent Children or Supplemental Security Income would be deemed to be poor for the purpose of computing subsidies. An employer's payments for health insurance on behalf of an individual would reduce the amount of the federal subsidy dollar for dollar. Medicare beneficiaries with income below 120 percent of the poverty level would receive a full subsidy of their premium for Medicare's Supplementary Medical Insurance--currently $493 a year.

Low-income people who chose to enroll in AHPs charging more than the reference premium would receive a reduction in their premium, but this reduction would be absorbed by other participants in the plan and not financed by the government. People with incomes up to 110 percent of poverty would pay only 10 percent of the difference between their plan's premium and the reference pre-

mium. This reduction in premiums would be phased out for people with incomes between 110 percent and 200 percent of poverty.

All non-Medicare enrollees with income below 200 percent of the poverty level would be required to pay only nominal cost-sharing amounts, as currently defined for the Medicaid program. Health plans would be reimbursed by the federal government for these cost-sharing subsidies based on the number and type of low-income people in the plan, not on the amount of services they used. Medicare beneficiaries with income below 100 percent of poverty would be exempt from all cost-sharing requirements. In this case, Medicare would pay providers the full amount allowed, and the Hospital Insurance Trust Fund would receive an appropriation to pay for the subsidies.

For individuals with family income below 100 percent of poverty, a wraparound benefit would cover certain items commonly covered under Medicaid, including prescription drugs, eyeglasses, and hearing aids. Specifically excluded would be long-term care services and services included in the standard benefit package. Because prescription drugs would most likely be covered in the standard benefit package, the prescription drug coverage in the package of wraparound benefits would primarily assist poor Medicare beneficiaries.

States would no longer be responsible for covering acute care for the former Medicaid population. They would, however, assume full responsibility for long-term care. This trade would provide substantial fiscal relief to most states. Moreover, states in which state and federal spending on long-term care exceeds the state's share of Medicaid would receive temporary federal financial assistance, which would be phased out over four years.

## Financing

Several changes in taxes and spending would finance the assistance to low-income people, the expanded deductibility of health insurance premiums for employees and the self-employed, and other smaller costs associated with program expansions. The proposal would cap the deductibility of health insurance expenses for employers, reduce payments to providers under Medicare, phase out Medicare's disproportionate share payments to hospitals, increase Medicare premiums for upper-income beneficiaries, require the Postal Service to prefund its retiree health benefits, and repeal Medicaid.

The proposal is intended to produce no increase in the federal budget deficit. If the savings fell short of covering the new federal costs, the proposal would scale back the amount of premium assistance provided to low-income people not eligible for Medicare. Under those circumstances, AHPs could not increase the premiums charged low-income people but would have to absorb the shortfall in federal payments by increasing premiums, reducing payments to providers, or other means. Alternatively, the Health Care Standards Commission could tailor the standard benefit package to fit the available funding, additional spending cuts could be made, or additional revenues provided.

To ensure that AHPs enrolling large numbers of low-income people were not disproportionately burdened by any shortfall in federal subsidies of premiums, the Health Care Standards Commission would establish a system to ensure the equitable distribution of the shortfall among health plans. This same reconciliation process would also be used to equalize reductions in premiums and cost sharing.

# Other Provisions

The proposal also contains provisions relating to health care services in underserved areas, graduate medical education, preventive health services, medical malpractice, and administrative simplification.

The proposal would improve access to health care in rural and other underserved areas by allowing HPPCs to require AHPs in the HPPC to serve such areas, promoting the development of AHPs in rural areas, authorizing additional funds for migrant and community health centers, and establishing a new system of Medicare payments for rural emergency access care hospitals.

Title III of the bill would alter the system of federal funding for medical education. It would establish a National Medical Education Fund, to be financed by a levy of 1 percent on the premiums of all AHPs and by payments from Medicare. The Health Care Standards Commission would approve programs for training medical residents and would pay each approved program out of the fund. The current medical education payments under Medicare would be repealed. The proposal would also increase funding for training midlevel practitioners, the National Health Service Corps, and area health education centers.

Title IV would expand preventive health services. It would increase authorizations for several public health programs, including immunization against vaccine-preventable diseases, prevention of lead poisoning, prevention of breast and cervical cancer, health information and health promotion, and the Preventive Health Services Block Grant. It would also expand Medicare to cover screening for colon and breast cancer, vaccination against influenza and tetanus-diphtheria, and well-child care for disabled children eligible for Medicare. The additional preventive services provided under Medicare would be financed by an increase in the premium paid by Medicare beneficiaries for Supplementary Medical Insurance.

Title V would establish uniform federal standards for malpractice claims, including limiting claims for noneconomic damages and reducing long statutes of limitations. It would also authorize grants to states to develop systems of resolving malpractice disputes other than through court proceedings and to develop medical practice guidelines.

Title VI would attempt to reduce the administrative costs of health insurance. Initially, the Health Care Standards Commission would establish goals for standardizing claims forms and electronic transmission of data. If the goals were not met, the commission would set standards and requirements for health plans.

Chapter Two

# The Proposal's Adherence to the Key Features of the Managed Competition Approach

The managed competition approach seeks to improve access to health insurance and to restrain the growth of health care costs by making consumers, insurers, and providers more conscious of cost. Such an approach would create purchasing cooperatives to improve access to affordable insurance for individuals and small groups. It would also increase insurers' incentives to compete on the basis of price and quality instead of by avoiding high-risk enrollees. The extent to which any managed competition proposal could achieve the full potential of this approach depends, in large measure, on the degree to which the proposal incorporates the following eight key features.[1]

- Regional health plan purchasing cooperatives (HPPCs) would oversee a restructured insurance market, with the objective of fostering competition among insurers on the basis of price and quality instead of by seeking to exclude high-risk enrollees.
- Access to insurance would be universal and on an essentially equal basis, accomplished by open-enrollment periods, community-rated premiums, and limited restrictions on coverage, to avoid current insurance practices that have made insurance unavailable to many individuals and small groups. (Under community rating, premiums vary only by type of enrollment and sometimes by the age or sex of the enrollee.)
- Insurance coverage would be universal, to avoid the shifting of costs for the uninsured to insured groups.
- All plans would offer a standard benefit package, to minimize nonprice differences so that consumers could more easily compare plans based on price.
- The HPPCs would provide comparable information on both price and the quality of care under each health plan, to facilitate competition based on those two factors.
- Health plans would have substantially nonoverlapping networks of affiliated providers, to facilitate each plan's ability to induce providers to adopt more cost-effective practice patterns.
- Payments from HPPCs to health plans would be adjusted for risk (while maintaining community-rated premiums for enrollees), to reduce plans' incentives to seek lower-cost enrollees rather than lower-cost means of providing high-quality care.
- The amount of tax-sheltered health insurance premiums would be limited to the level of the least expensive plan offered through the HPPC in each region, to make consumers more conscious of costs.

This chapter discusses the extent to which the Managed Competition Act incorporates each of these key features. In brief, the proposal lacks one (the assurance of universal coverage), but it has part or all of the other seven. The chapter concludes

1. These features were identified and discussed in greater detail in Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (May 1993).

with a description of the Congressional Budget Office's (CBO's) assumptions regarding the degree to which the growth of health care costs would be restrained by the managed competition features of the proposal.

For the most part, the discussion in this chapter assumes that the standard benefit package would be comprehensive, covering most health care needs. If, instead, the standard package was so limited that many people purchased supplementary insurance, then a substantial portion of health care spending would take place outside the system of managed competition. Consequently, the effects of managed competition would also be limited, and many of the problems evident in the insurance market now would be present in the market for supplementary insurance.

## Regional Health Plan Purchasing Cooperatives

Conceptually, regional health plan purchasing cooperatives are a key element to the success of managed competition. HPPCs are intended to integrate the market for health insurance sold to individuals and small employers, which is currently segmented by risk. By organizing the demand side of the market and enforcing open access to health insurance, the HPPC would create countervailing power for purchasers in their relationships with insurers. In addition, the HPPC would restructure competition within insurance markets by providing clearer information about the differences among insurers' networks of providers, reducing incentives for insurers to engage in nonprice competition based on enrolling low-risk members, and increasing incentives for insurers to reduce premiums by delivering high-quality care to their enrollees in more cost-effective ways.

The proposal would establish a single HPPC in each region to coordinate all offerings by accountable health plans (AHPs) to individuals and small employers. The HPPC would provide information on each plan's price and quality of care; it would also collect premiums from enrollees and make risk-adjusted payments to the plans.

Under this proposal, however, the role of the HPPC would be more limited than might be necessary to achieve fully the objectives of managed competition. A significant proportion of the insured population in each state would be outside the authority of the HPPC because large employers could not obtain insurance through it. The proposal defines a large employer as one with more than 100 employees, but it would allow states to raise this threshold as long as no more than half of all employees in the state would then be eligible to obtain insurance through a HPPC. Because the HPPC's pool of insured people would exclude those in plans offered by large employers, it would be smaller and higher in risk than a pool that included all AHPs in the region.

Even for HPPC-sponsored health plans, the HPPC would not be permitted to bargain or otherwise influence plans' premiums or the rates paid to providers. In addition, the HPPC would have no authority to approve or disapprove health plans seeking to offer insurance in the region--this authority would reside, instead, in the new federal Health Care Standards Commission.

## Universal Access to Insurance

The proposal would ensure universal access to health insurance, and it would provide subsidies to low-income people to help them pay the costs of that insurance. All HPPC-sponsored AHPs would have to hold open-enrollment periods and charge community-rated premiums. Plans could not deny coverage on the basis of health status, and they could restrict coverage for preexisting conditions only for the first six months of a new policy.

The proposal would not, however, guarantee universal coverage. In the absence of a requirement for such coverage, people who anticipated relatively high costs for health care would be more likely to purchase insurance than people who expected relatively low costs. With a portion of the population remaining uninsured, per capita insurance costs for the insured population would be higher, compared with universal coverage, for two reasons. First, the

average level of risk among those who purchased coverage would be higher than the level among those who did not. Second, when uninsured people required care, providers would probably shift any uncompensated costs for that care to the insured population through higher charges that would be reflected in higher insurance premiums.

## Standard Benefit Packages and Comparative Information

In addition to the tax cap discussed in a later section, two other features of the proposal would encourage price consciousness in health insurance and health care markets. First, all AHPs (both the open plans offered through the HPPC and the closed plans offered by large employers) would have to offer a standard benefit package, which would facilitate meaningful price comparisons among plans because the product would be uniform. Second, the HPPC would be required to compile comparable information--not only about price but also about quality of care--for all its AHPs to help purchasers balance quality against costs when choosing a plan.

Both open and closed AHPs would have to meet similar requirements with regard to the standard benefit package, which would include a standard cost-sharing requirement. The proposal's provision for a standard benefit package would override current laws in some states that require insurers to cover specific services.

Plans could offer benefits beyond the standard package subject to two conditions: the extra benefits could not reduce cost-sharing requirements on the standard benefits, and the extra benefits would have to be offered and priced separately from the standard package. Anyone eligible to purchase insurance through the HPPC could purchase an open AHP's supplemental policy, whether or not they purchased that plan's standard policy. The latter condition would help to ensure that insurers' supplemental benefits would not become a means for their achieving favorable risk selection in their standard health plans.

## Nonoverlapping Networks of Providers

To realize fully the potential savings from managed competition, insurers would have to compete vigorously with respect to price and quality of care. Effective competition would probably require that insurers have nonoverlapping networks of providers. If, instead, most providers were affiliated with several insurance networks, price differences among the plans would mostly reflect differences in discounts that the plans had negotiated. Providers' incentives to adopt the cost-effective patterns of treatment encouraged by any one of the networks they served would be weakened in direct proportion to the percentage of their patients whose insurers were associated with other networks.

The proposal would override laws that in some states require managed care plans to enroll all providers in the service area who wish to serve the plan's membership. Thus, the proposal would permit insurers to form nonoverlapping networks of affiliated providers, but to what extent insurers would actually do so is unclear. Competitive pressures might be sufficient to induce insurers to develop such networks, but the incentives would be even stronger if insurers were held accountable for the quality of care provided under their plans.

Effective accountability for the quality of care provided under their health plans would substantially change the incentives insurers now face. It would encourage much closer scrutiny of the providers they enrolled and closer involvement in the day-to-day practice of those providers. A degree of accountability would be achieved through the discipline of a market in which consumers were well informed about differences in the quality of care provided through each network; under the proposal the HPPC would provide such information to individual consumers and small employers. Another, more certain way to achieve accountability would be to hold insurers liable, along with their affiliated providers, under current standards for malpractice, but the proposal has no such provision.

## Risk-Adjusted Payments to Health Plans

In any system that required open enrollment with community-rated premiums but that had no mechanism to neutralize the financial effects of risk selection, the main factor determining profitability for insurers would be how successfully they could attract relatively healthy enrollees. Under the managed competition approach, even if the benefit package was uniform and enrollment in plans was controlled by the HPPCs, plans might nevertheless find ways to achieve favorable risk selection. For example, plans might target their marketing to more active (and presumably healthier) people, or they might limit the number of affiliated physicians in strategic specialties. Plans with limited access to cardiologists, for instance, would be unlikely to attract many people with heart disease.[2] Without compensating payments, plans that enrolled a relatively large proportion of high-cost members might be unable to compete because of the characteristics of their membership, even if they provided care very efficiently.

In principle, the proposal would establish a system of payments to compensate plans for differences in risk, but no accurate mechanism currently exists to calculate such payments. Also unclear is how quickly risk-adjustment mechanisms could be developed or how accurate they would have to be to eliminate incentives for plans to compete based on risk selection rather than price and quality. What is certain is that without a mechanism that was "good enough," efficient plans would not necessarily be rewarded appropriately.

## Limits on the Amount of Tax-Sheltered Insurance Premiums

One of the key elements of managed competition is limiting the amount of tax-sheltered health insurance premiums to the cost of the least expensive plan available to each enrollee. Because the additional cost of purchasing a more expensive plan would not be subsidized through the tax system, consumers would be more conscious of the cost of health insurance. This awareness, in turn, would make insurers more conscious of the costs they incurred to provide benefits.

Under the proposal, only premiums for plans that met the requirements established by the Health Care Standards Commission--accountable health plans--would be deductible, and for these plans the tax preference would be limited. The proposal would cap the currently unlimited tax subsidy for employment-based health insurance by imposing an excise tax on employers' contributions that were above the premium for the lowest-cost plan in the HPPC--the reference premium. (If an employer contributed less than the amount of the reference premium, the difference between the reference premium--or the actual premium, if less--and the employer's contribution could be deducted from taxable income by the worker.) The proposal would also allow self-employed people and individual enrollees to deduct premium payments, up to the amount of the reference premium, from their income. That provision would expand the tax subsidy for these people because most premiums paid by individuals do not qualify for tax subsidies under current law.[3]

## The Effect of the Current Unlimited Tax Subsidy on Spending for Health Care

Health care costs are high in part because health insurance premiums are subsidized through the tax code. Employers' contributions toward the cost of employees' health insurance are not taxable compensation. Unlike cash wages, they are not subject to income or Social Security payroll taxes. As a result, saving a dollar's worth of employment-based

2. See J.P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, vol. 13, no. 1 (Spring (I) 1994).

3. For self-employed people and other individual purchasers, insurance premiums up to the cap would be a deductible expense for income tax purposes but not for calculating liability under the Social Security payroll tax.

health insurance gains the typical employee in 1994 only 74 cents in take-home pay.[4]

The tax subsidy for employment-based health insurance has encouraged employers to sponsor health insurance coverage for their employees. About 75 percent of workers and their families are covered by such insurance. But the subsidy has also discouraged workers and employers from seeking less expensive forms of health insurance because the tax subsidy is unlimited. Because the subsidy is more valuable for comprehensive health insurance with few controls on costs than for more economical health insurance coverage, employers exert less pressure on insurers to control costs than they otherwise would.

The subsidy adds to health spending in two ways. First, people tend to buy more of anything, including insurance, when its price is reduced. Second, the additional spending on insurance indirectly translates into additional spending on health care. People with health insurance pay little or none of the cost of care when they get sick; instead, insurance pays the cost for them. As a result, they and their doctors have little incentive to pay attention to the costs of diagnostic and treatment options.

## The Effect of the Tax Cap in the Proposal

Limiting the tax subsidy by imposing a tax cap of some form would encourage employees and employers to choose more cost-effective health insurance. One type of cap would require employees to include in their taxable income the portion of their employer's payments for health insurance premiums that exceeds the cost of the lowest-cost plan available to them--the cap amount. Another option would prohibit employers from claiming as a business income tax deduction any health insurance payments in excess of the cap amount. A third option, which is the approach taken in the proposal, would apply an excise tax to employers' contributions in excess of the cap. (Like other excise taxes, the 35 percent excise tax in this proposal would be a deductible business expense.)

**Effect on Employers' Contributions for Health Insurance.** Under the proposed tax cap, an employer that contributed more than the amount of the reference premium would have to pay a 35 percent excise tax on the excess contribution. That tax would be passed on to employees in the form of lower cash wages. Thus, employees would ultimately pay the tax even if the employer chose to contribute more than the cap amount. If, instead, the employer limited its contribution to the amount of the cap, employees could select a more expensive plan, but they would pay the additional cost out of after-tax, rather than pretax, income. In other words, if the excise tax caused employers to limit their contributions to the reference premium, the tax would have the same effect as a limit on the amount of health insurance premiums that could be excluded from employees' taxable income.

The excise tax would create a strong incentive for employers to limit their contributions to the reference premium, but the cap in the proposal would constrain the choices of some employers and their employees more than others. For small employers, who would have to obtain coverage through the HPPC, the cap would--by definition--equal the cost of the lowest-cost AHP available to their employees. Thus, any additional expenditures for health insurance would either be subject to an excise tax, if the employer paid the additional premium, or income and payroll taxes, if the employee paid it.

Because a large employer--generally, one with more than 100 employees--that wanted to pay for insurance for its employees would be required to purchase insurance outside the HPPC, the premium for its lowest-cost plan would not necessarily equal the reference premium. Plans sponsored by employers whose workers were less healthy than the average participant in the HPPC areas in which the firm operated would typically cost more than the reference premium. Those employers would be least likely to pay more than the premium for the least expensive plan available to them. Moreover, if they limited their contributions to the cap amount, employees who wanted health insurance would have

4. See Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994).

to pay the amount in excess of the reference premium out of after-tax wages.

But some other large firms would be less constrained by the cap in the proposal. Their premium for a plan that covered the standard benefits would be less than the reference premium because their workers would be healthier than average.[5] These firms would still have a strong incentive to limit their contribution to the cap, but that contribution might pay for basic insurance that cost more than the reference premium or for supplemental health insurance policies offered through an AHP. Thus, the cap would constrain the behavior of those large firms less than the behavior of small firms under the proposal.[6]

The adjustment of employers' contributions to the cap levels might take several years. Over the short run, employers might continue to make contributions that exceeded the reference premium--because of multiyear labor contracts, for example.[7] But over time, most would have a strong incentive to limit their contributions to the amount of the cap and increase employees' wages. An employer who contributed more than the cap would have to pay excise taxes on its excess contributions for all employees--even for those employees who would have been satisfied with a plan that could be purchased for the reference premium. Thus, the employer would be paying a tax (plus the additional premiums) to provide a benefit that was valuable only to some employees. By limiting contributions to the amount of the cap, the employer could make employees who chose the low-cost plan better off; employees who preferred the high-cost plan could still pay the extra premiums out of after-tax income.

Over the long run, firms would be likely to pay more than the cap amount for their employees' health insurance only if almost all employees agreed that they wanted a health insurance plan with a premium that exceeded the cap. Those employees would pay less for their insurance if their employer paid the 35 percent excise tax and passed on the tax in the form of lower wages than if they had to pay the extra premiums out of after-tax wages.[8] The less comprehensive the standard benefit package, the more likely it would be that employees would agree on additional health benefits. Thus, more firms would elect to offer health insurance that exceeded the reference premium (and would thus incur the excise tax) under a limited standard benefit package than under a more comprehensive one.

**Effect of a Tax Cap on the Choice of Health Insurance Plans.** An example illustrates how a tax cap, such as the one in the proposal, would provide a stronger incentive than exists at present to select low-cost health insurance. Suppose that the low-cost health insurance plan in an area costs $4,000 for family coverage and that the high-cost health plan costs $5,000. Under current law, if the employer is willing to contribute the entire premium (in exchange for paying lower cash wages), every dollar of health insurance costs the employee a dollar of cash wages minus the income and payroll taxes that would be paid on those wages. An employee subject to a marginal tax rate of 30 percent who was covered by the low-cost health insurance plan for $4,000 would save $1,200 in taxes compared with receiving the $4,000 in cash wages (see Table 2-1).[9] If the employee was covered by the

5. The proposal would also allow large employers that maintained a closed AHP to elect to use simplified rules for computing the reference premium. For example, an employer with younger-than-average employees would have a higher tax cap if it elected to use a "community rate" reference premium rather than one based on the age composition of its work force. That election might allow the employer to avoid the excise tax or to offer additional health benefits without exceeding the tax cap.

6. Some self-insured firms might also be able to circumvent the caps by recharacterizing insurance costs as company overhead or by artificially reallocating costs from enterprises with low insurance costs to those with high costs. For a discussion of this issue, see Chapter 6 of Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance.*

7. The proposal provides a temporary exception from the excise tax for health insurance contributions made by employers as part of a collective bargaining agreement ratified before the date of enactment of the proposal, or January 1, 1998, whichever is earlier.

8. Because the reduction in wages as a result of the excise tax would reduce employees' income and payroll tax liability, the effective tax rate on the excess premiums paid by the employer would range from 20 percent to 25 percent for employees with taxable income. Those rates are lower than the combined income and payroll tax rates for most employees, so employees who preferred a more expensive health insurance plan would rather have their employer pay for it--and pay the excise tax--than receive the additional compensation as taxable wages.

9. The 30 percent tax rate corresponds roughly to the combined income and payroll tax rates (both the employer and employee

**Table 2-1.**
**Employees' Incentive to Purchase More Expensive Health Insurance Under Present Law, a Tax Cap, and No Tax Exclusion (In dollars)**

| | Low-Cost Insurance Plan | | | | High-Cost Insurance Plan | | | | Additional Cost of High-Cost Plan After Taxes |
|---|---|---|---|---|---|---|---|---|---|
| | Before-Tax Cost | Amount Excluded from Taxes | Tax Savings | After-Tax Cost[a] | Before-Tax Cost | Amount Excluded from Taxes | Tax Savings[a] | After-Tax Cost | |
| Present Law (Full exclusion) | 4,000 | 4,000 | 1,200 | 2,800 | 5,000 | 5,000 | 1,500 | 3,500 | 700 |
| Tax Cap of $4,000 | 4,000 | 4,000 | 1,200 | 2,800 | 5,000 | 4,000 | 1,200 | 3,800 | 1,000 |
| No Tax Exclusion | 4,000 | 0 | 0 | 4,000 | 5,000 | 0 | 0 | 5,000 | 1,000 |

SOURCE: Congressional Budget Office.

a. Based on a marginal tax rate of 30 percent.

high-cost plan for $5,000, the tax savings from the exclusion would increase to $1,500. Thus, the additional cost of the more expensive plan after taxes is only $700. When the additional services or reduced cost sharing in the more expensive plan are worth more than $700, under current law an employee would choose the more expensive plan, even though the additional premiums cost $1,000 before considering the tax savings.

Suppose that under the proposal the employer chose to contribute only $4,000. The cost to the employee of the low-cost health insurance plan would not change because the employer's contribution would continue to be fully excluded from taxation. If the employee paid the additional $1,000 in premiums for the high-cost health insurance, the tax savings would not change because of the cap. As a result, the after-tax cost of insurance would increase from $2,800 to $3,800. The additional cost would be the same as if no tax exclusion had existed at all (see Table 2-1). Thus, if the cap was in place, the employee would choose the more expensive plan only if it was worth its full additional cost. For example, if the additional services covered under the high-cost plan were worth only $850 to the employee, the cheaper plan would be chosen under the tax cap. But under present law, the employee would choose the more expensive plan.

## Assumed Effects of the Proposal on the Growth of Health Care Costs

If the standard benefit package was a comprehensive one, the Managed Competition Act would put in place, to some degree, all of the features important to the success of managed competition except universal coverage, but it would be unlikely to realize the full potential of that approach to containing health care costs. Its potential would be enhanced if the HPPCs had more power to negotiate with AHPs and if everyone purchased health insurance through these cooperatives (which would mean that an effective tax cap would apply to them all). Achieving the full potential of managed competition would also depend on developing an adequate mechanism for adjusting payments to plans to compensate for

shares) for a taxpayer in the 15 percent income tax bracket. Note that eventually the immediate savings in payroll taxes are offset in part by lower Social Security benefits than would be paid if all compensation had been in the form of wages.

risk selection; this problem, however, is one that would affect all managed competition proposals.

CBO assumes that the proposal would restrain the growth of health care costs through two main avenues. First, the incentives created by the managed competition environment would accelerate the shift in insurance enrollment that is already under way toward effectively managed plans. CBO assumes that this effect would slow the growth in costs of AHPs by 0.6 percentage point per year for the first five years, compared with the rate of growth that would result under current law. Because of this effect, national health expenditures by the year 2000 would be about 1 percent lower than they would be otherwise.

Second, CBO assumes that the competitive pressures fostered by the proposal would cause all insurers to intensify their efforts to control costs. How successful they would be, and the resulting effect on the growth of overall health care spending, are uncertain. There are no credible estimates of the potential savings under managed competition, largely because this approach is untried. Although some features of managed competition exist in California, Minnesota, Wisconsin, and perhaps a few other states in which large purchasing cooperatives have been formed in recent years, the broader context in which these cooperatives operate differs from the environment that would exist under current managed competition proposals. For the cost estimates provided in the next chapter, CBO assumes that the competitive pressures created by the proposal would dampen the rate of growth of costs of AHPs by increasing amounts over a 10-year period, until the restraint amounted to a 1 percentage-point reduction in the rate of growth of these costs for each year after 2004.

These assumptions are used for both of the alternatives examined in the next chapter--one based on a comprehensive standard benefit package and one based on a more limited package. Growth in national health expenditures would be more constrained under the comprehensive package than under the limited one, though, because a larger portion of that spending would flow through the managed competition system if the package was comprehensive. Thus, in 2004 the estimated rate of growth in national health expenditures would be 7.6 percent under the alternative with a comprehensive standard benefit package, 7.8 percent under the alternative with a more limited package, and 8.2 percent under current law. However, a great deal of uncertainty surrounds these estimates.